

BOONE COUNTY INTERAGENCY REFERRAL ----- 2011-2012

Please **complete** the information as **completely and accurately** as possible. If unknown, leave blank.

Name of student (and children, if family referral)	DOB (of each person referred)	Gender (of each person referred)	Lives in same home? Y/N

Referring Agency _____ Referred by _____ Contact number _____

Student's Address _____ City/Zip _____

Custodial Parent(s) _____ Phone _____

Non-Custodial Parent(s) (if applicable) _____ Phone _____

Address _____ City/Zip _____

School _____ Grade _____

Check the following agencies that have been/are involved with the student/family and provide dates of service and contact names, if known.

Dates of Service/Contact Person

- | | |
|---|-------|
| <input type="checkbox"/> Children's Division/Family Support Division | _____ |
| <input type="checkbox"/> City/County Health Dept. | _____ |
| <input type="checkbox"/> Division of Alcohol & Drug Abuse | _____ |
| <input type="checkbox"/> Division of Youth Services | _____ |
| <input type="checkbox"/> Educational Services | _____ |
| <input type="checkbox"/> Juvenile Office | _____ |
| <input type="checkbox"/> Mental Health/Burrell Behavioral Health | _____ |
| <input type="checkbox"/> Mental Health/Missouri University
Psychiatric Center | _____ |
| <input type="checkbox"/> MR/DD - Central Missouri Regional Office/
Boone County Family Resources | _____ |

Other interested parties/agencies:

Name

Address/Phone

Why are you making this referral? (Use a separate sheet if you need more space)

What would you like to have happen as a result of this referral/meeting?

What would parent(s)/guardian like to have happen as a result of this referral/meeting?

Please list the child's strengths. What are the family's strengths?

Education

Student is on grade level and making passing grades

Student has been suspended from school

Student has good attendance

Student has positive relationships with peers

Student responds appropriately to authority figures

Student has an IEP / 504 /Special Health Care Plan (circle)

Yes No Unknown

☐ ☐ ☐

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If yes, diagnosis: _____

Student has attended: ☐ Headstart ☐ Preschool ☐ Early childhood special education

Substance Abuse	Yes	No	Unknown
Child uses drugs and/or alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physical and Mental Health	Yes	No	Unknown
Child has a medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain _____			
Child receives routine medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list providers _____			
Child is prescribed medication(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list _____			
Developmental concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe _____			
Child has seen a doctor or counselor for psychiatric/emotional/behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list providers _____			
Child has been hospitalized for psychiatric/emotional/behavioral problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list dates _____			
Child has insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list insurance provider _____			

Behaviors

Child displays/has displayed the following behaviors (Check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Physical aggression | <input type="checkbox"/> Runaway |
| <input type="checkbox"/> Sexual acting out | <input type="checkbox"/> Verbal aggression |
| <input type="checkbox"/> Self harm | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Isolation/Withdrawn |

Other behaviors of concern not listed above:

Child Abuse/Neglect History	Yes	No	Unknown
Child has history of physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has history of sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child has been removed from home due to abuse/neglect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY SITUATION

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Homeless/Housing issues |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Parental separation |
| <input type="checkbox"/> Domestic violence | <input type="checkbox"/> Physical health problems/handicap |
| <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Significant family trauma |
| <input type="checkbox"/> Family member with law violations | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Frequent relocation | |

Other family issues of concern not listed above:

Who else lives in the home?

<u>Name</u>	<u>Relationship</u>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

AUTHORIZATION TO EXCHANGE INFORMATION

I, _____ request and authorize the following persons and/or agencies as listed in this document to openly and cooperatively share information concerning my child/children/ward(s), _____, and concerning his/our family at an interagency planning meeting. This information may include personal and social history information concerning my child/children/ward(s) and his/our family.

Additionally, I authorize continuing or ongoing planning by representatives from the agencies among themselves for the same purpose of developing a plan of services for my son/daughter/children and my family. This authorization is given to assure that such planning and any resulting services are provided in a coordinated manner.

The actual provision of any services resulting from this planning shall be subject to advance parental and/or guardian authorization separately from this authorization given today.

This consent will expire **one year from the date below**, unless consent is revoked prior to one year.

- Boone County Children’s Division / Family Support Division
- Boone County Family Resources
- Boone County Juvenile Office
- Central Missouri Regional Office, Department of Mental Health
- Columbia Public Schools/Other School_____
- Columbia/Boone County Health Department
- Division of Youth Services
- Missouri University Psychiatric Center
- Pathways
- Burrell Behavioral Health

Signature of authorizing parent or guardian:

Date

To revoke consent:

I, _____, hereby revoke my authorization to release information concerning my child/children/ward and family.